October 9, 2011

Dear Representative Pete Lund:

My name is Julie Ladwig. I am a licensed physical therapist from Lake Orion that has worked in Michigan for 25 years. Much of my experience was at Beaumont Hospital. I have experienced how all of the different payer sources work for the patients I have served that have sustained devastating life-long injuries to their brain and/or spinal cord. I am writing this letter to you in regards to House Bill 4936. I am opposed to this bill. The Auto No-fault system is working and there are checks and balances in this system to control the costs. The focus of my letter to you today is in regards to the concern I have with using the workman's comp fee schedules to determine reimbursement levels for those that have sustained catastrophic injuries.

In my 25 years as a Physical Therapist, I have seen many different types of patients and have worked with private, public, auto and workman's comp as reimbursement sources. The best way for me to discuss this is to share some different case studies and outline the significant differences in clinical need for different diagnoses.

Most workman's comp injuries involve broken bones, strained ligaments, joint problems, and muscular problems from inflammation/overuse. There are rare incidents of injury to the central nervous system (brain and spinal cord), typically from falls of great distance or driving on the job. Here are some cases to allow us to dive into more detail in this area:

Case 1: (Worker's Compensation Funding)

35 year old male that is part of a roughing crew and injures his shoulder from overuse. He needs to go to physical therapy only and receives ultrasound, moist heat, massage, manual therapy, exercise, and ice. He is cognitively intact and can work relatively independently on his exercise program and only requires the individual attention of his therapist for 15 to 20 minutes. He is in the clinic for an hour receiving the above outlined treatment modalities. While he is being treated the same clinician has 2 other patients going at the same time. In essence the clinician can see 3 patients in one hour and each patient is billed for approximately one hour of clinical intervention.

Case 2: (Health Insurance Funding)

45 year old male that is in the prime of his career. He is a successful businessman working as a hospital administrator. He is at work one day and starts to talk funny, loses his balance, has facial droop, and has weakness on the left side of his body. He has just had an brain aneurysm rupture and his life will be changed forever. He has private insurance. We will use Blue Cross as an example. There are "rules" to his rehabilitation. Limited number of visits; different disciplines have to be on the same day to maximize his time in rehabilitation. He has to learn to speak again, eat again, dress, bathe, groom, walk, write,

visually scan his environment, process verbal and written information, organize, mathematical skills for his business job. The list goes on and on. The therapists have 60 visits per year to get him back to functioning close to the way he was before the day of his aneurysm. More than likely someone in his family will need to be home with him to supervise him as he has no safety awareness and reduced judgment. Not only has his income changed, but now his wife has to quit her job to become his caregiver. This causes a significant reduced income due to this medical event that occurred in the prime of his life. After several months, a decision will be made that he will not have the ability to return to his administrative job so he is separated from his employment. He can "COBRA" his health insurance but it is very expensive (remember, his wife had to quit her job to be with him)but this will cover himself and his family for the next several years. He applies for and receives Social Security Disability Insurance and Medicare when he has been disabled for two years. His family has used up all their savings now and his wife decides that she has to work for the sake of the children. She divorces him and he moves to a nursing home where Medicaid and Medicare cover his cost of care for the rest of his lifetime.

Case 3: (Medicare Funding)

65 year old woman is visiting her daughter and experiences a fall at her daughter's home when adjusting a shower curtain. She hits the back of her head on the ceramic sink in the bathroom and becomes a C5 complete quadriplegic. She is not affected cognitively but her life physically has dramatically changed and she will require care for the rest of her life. She can move her head, neck, shoulders, and biceps. She has no hand function and nothing below her neck that works. She has no trunk support, bowel function, bladder function. She is prone to pressure sores, osteoporosis, contractures, Autonomic Dysreflexia, and increased risk for pneumonia. She is insured through the Medicare system. She can't tolerate 3 hours a day of therapy so she is unable to qualify for in-patient rehabilitation. She goes home with the recommendation of out-patient therapy. She has to relearn how to feed herself, assist with dressing, bathing, and learn to instruct others how to care for her. This will fall under part B of her Medicare coverage. We have approximately 30 days or 12 visits to get this done or else the out-patient clinic will take the risk of losing reimbursement for services. Her husband, also recently retired becomes her care giver for the next two years but then he hurts his back. She and her husband have no choice but to move her to a nursing home. Their savings are quickly depleted, she qualifies for Medicaid, and will live away from family for the rest of her lifetime.

Case 4: (Auto No Fault Funding)

20 year old male college student is driving home on a winter day and he loses control of his vehicle on black ice. He collides head on with a pick-up truck when he crosses the median. He sustains a cervical level spinal cord injury. He has trace use of his arms/hands only and he is emotionally devastated. He was going to college to become an accountant. He will require Physical Therapy, Occupational Therapy, Speech Therapy, Psychological Support, Vocational therapy and Recreational Therapy. He gets several years of intensive rehab, completes his degree, and is now working. He does require an attendant because he cannot perform his own transfers; bowel and bladder care, of dress himself, or eat independently.

In Summary, to assume that a fee schedule that was adopted to cover worker's who sustain mostly orthopedic injuries for back, neck, shoulder, leg, and hand injuries would work for neurological injuries is unrealistic. The intensity of rehabilitation between these different injuries and the amount of one on one time that is needed with the therapist is very different. If any of you have had an orthopedic injury that required therapy you can relate to what I am explaining. I was speaking to a co-worker last week about the fee schedule portion of House bill 4936. He explained to me that after his shoulder surgery he received Physical Therapy. He stated that his therapist spent 5-10 minutes with him every time he came in for therapy. She did the manual work on his shoulder and then he did exercises while she was working with other clients. This is NOT possible when you are working with someone that has sustained a neurological injury. The patient can't work independently. They require the skilled care of the clinician during the session. There is no way to "double or triple up" on patients that have traumatic brain injuries or spinal cord injuries. It can't be done.

To modify the current practice of reimbursement to clinics that treat neurologically involved clients that have sustained a catastrophic injury to the fee schedule will not work. Patients will not be able to get the intensive skilled therapy they require for recovery and clinics will not be able to survive on that level of reimbursement. There will be fewer clinics that will even treat people with these injuries because the businesses will not be able to survive. A shoulder injury does not come anywhere close to comparison to a TBI and/or SCI.

What I have found interesting during the last two days of testimonies is the assumption that people that sustain catastrophic injuries due to a motor vehicle accident get whatever they want whenever they want it. This is just not the case. There are many checks and balances within the system. Many times letters of medical necessity have to be written and signed by the treating physician. The sky is not the limit when it comes to getting things for people that have had devastating injuries due to a car accident. These cases are complex and have an entire team that is working collaboratively to determine what the best thing is for the patient clinically. There is the interdisciplinary team, case managers, physicians, and adjuster working together. This system is not a free for all....get whatever your heart desires. However, the patient should be able to get what they need when they need it and not have to wait months. There is a way to monitor the costs related to rehabilitating someone that has had this devastating injury.

In conclusion, the Auto No-fault system is working. It is not a system of unlimited benefits with patient's getting whatever they ask for. There are professionals that are making the recommendations and there are systems in place to help monitor the costs. Just as other businesses have to have quality control in place, so do the insurance companies. Thus far the auto insurance companies have not even guaranteed that the people would even save anything on their auto rates. It just does not make sense to support PIP choice or workman's comp fee schedules. These fee schedules will NOT work for clinics that treat patients with catastrophic injuries, nor will it work for attendant care and needed nursing care in the home.

<u>Here are some of the realities of this bill being passes:</u>

1. It will be an economic and Job killer- it is expected that 2500-5000 jobs will be lost

2. There is NO guarantee that insurance rates will go down.
3. There will be increased litigation thus liability insurance will go up and there will be more lawsuits.
4. Currently Michigan's Auto insurance rates are just above average in the nation. It is not true that our rates are significantly higher than other states; in fact 10 states have more expensive insurance than we do...without the benefit of a comprehensive safety net of care and services.
5. Overall Michigan's liability and PIP coverage is $22 more per year than average American automobile. It is #1 in quality, and average in cost and not anywhere near the most expensive. Why would you mess with this?
6. There WILL be a cost shift to Medicaid and other Welfare Programs. If this bill passes, people that suffer catastrophic injuries will be forced into bankruptcy and onto the state Medicaid system to pay for their care.
7. This legislation is a cost shift to taxpayers.
8. Tens of millions of dollars each year will be shifted to our Medicaid system. Can our state really afford this?
9. Injured victims will not have the opportunity to get better and will miss valuable rehab.
10. The fee schedule will not work the same for neurological injuries as it does for orthopedic injuries. It is not apples to apples.

Thank you for your time and I ask you to oppose House bill 4936.

Sincerely,

Julie Ladwig

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